

WAGE AND SALARY VERIFICATION

Current Date	Our Policyholder	Date of Accident	Claim Number	Policy Number
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NOTICE - Section 817.324, Florida Statutes, provides in part: "Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

EMPLOYEE'S NAME _____

EMPLOYEE'S ADDRESS _____

Gentlemen:

The above named person has applied for benefits under the "No-Fault" Insurance as a result of injuries in an automobile accident on the date indicated. We understand this person is your employee or former employee. To determine benefits that may be due the applicant, this law requires you to provide us with the answers to the following seven questions, and to return this form properly. Thank you for your cooperation.

TO: CLAIMS DEPARTMENT

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1. DATES OF EMPLOYMENT FROM: _____ THROUGH: _____
2. DATES ABSENT FOLLOWING ACCIDENT: FROM: _____ THROUGH: _____
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3. WAS EMPLOYEE PAID DURING THIS ABSENCE: YES NO IF "YES" AMOUNT PAID: _____
4. IS EMPLOYEE ENTITLED TO BENEFITS UNDER WAGE OR SALARY CONTINUATION PLAN? YES NO
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5. NAME OF WORKMEN'S COMPENSATION INSURER _____
6. HAS OR WILL A CLAIM BE FILLED UNDER ANY WORKMEN'S COMPENSATION LAW FOR THIS ACCIDENT? YES NO
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7. SCHEDULE OF WEEKLY EARNINGS - FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

Week No.	Week		No. of Days Worked	Amount Earned Including Overtime or Extra Work	Gratuities				Gross Earnings
	From Date	To Date			Meals	Board	Tips	All Other	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
TOTAL									

EMPLOYER	DATE	SIGNED	TITLE
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